Department of Public Health and Human Services	Section: APPLICATION PROCESSING
MEDICAL ASSISTANCE	Subject: Disability Determination Overview

Supersedes: MA 105-1 (02/01/05)

References: 42 CFR 435.541, .911; ARM 37.82.101, .204

GENERAL RULE--An individual applying for Medicaid based on disability must meet the Social Security Administration's (SSA) disability criteria. The SSA will determine disability for:

1. Social Security Disability Insurance Benefit (SSDI) applicants; and

   As a condition of eligibility, applicants with work histories and those who may qualify for SSDI benefits through a parent's or present or former spouse's work history must make application for Social Security Disability Insurance (SSDI) no later than during the Medicaid application process OR within five months of the stated onset of disability, whichever comes later.

   NOTE: If an individual may be "DAC" eligible, a referral to Social Security Administration for SSA income based on "Application for Other Benefits" criteria may be appropriate. See MA 304-1.

2. Supplemental Security Income (SSI) applicants.

   NOTE: For Medicaid purposes, individuals eligible for SSDI or SSI have met the Medicaid disability criteria. Clients must continuously meet the disability criteria to retain Medicaid eligibility.

VETERANS ADMINISTRATION DISABILITY

An individual eligible for Veterans Administration disability benefits does **not** automatically meet SSA disability criteria. **Therefore, veterans must complete a SSA or MEDS (Medicaid Eligibility Disability Services) disability determination process.**

►DISABILITY

When application for Medicaid is made on behalf of a

BASED ON DEATH deceased individual, disability criteria is assumed to have been met for the month of death, and possibly for the retroactive period. See MA 105-3 for disability determination procedures for a deceased applicant.

MEDS DISABILITY DETERMINATION REQUIREMENTS The Department of Public Health and Human Services (DPHHS) is required to make a disability determination through MEDS when a Medicaid applicant:

1. has not applied for SSI cash benefits;

   NOTE: Application for SSI cannot be required of Medicaid applicants or recipients.

2. has applied for SSI benefits and is found ineligible for benefits for a reason other than disability (e.g., excess income or resources);

   NOTE: When SSI benefits have been denied because the client's income exceeds the SSI limits, the client may meet Medicaid eligibility criteria for other programs (e.g., medically needy).

3. has applied for SSDI benefits and is found ineligible for a reason other than disability (e.g., insufficient creditable quarters of work);

► 4. has applied to SSA for SSI and/or SSDI and separately to DPHHS for Medicaid and the SSA has not made a disability determination within 90 days of the later of the SSA application date and the separate Medicaid application date;

5. applies for Medicaid and alleges a disabling condition which is different or in addition to that considered by the SSA and the SSA/SSI appeals processes have been exhausted (appeals are considered exhausted when the decision has been appealed through reconsideration, Administrative Law Judge and Appeals Council); **or**

6. applies for Medicaid more than twelve (12) months after the SSA has made a final determination that the applicant was not disabled.

► **NOTE:** If a MEDS determination is done due to circumstances outlined in either #5 or #6 above, and the individual is found disabled by the MEDS process, the individual will be required to reapply for SSDI benefits (when adequate work quarters exist).

► If a Medicaid applicant/recipient is alleging a disability, and is in appeals status with SSA regarding disability criteria, MEDS cannot be used to determine eligibility. The ABD Medicaid coverage request will be denied and the individual must continue to pursue his/her disability status through SSA.

If a Medicaid applicant is alleging a disability and has been denied disability status by SSA within the past 12 months and is not in appeals status, s/he must pursue the disability status through SSA either by appeal or reapplication. MEDS cannot be used to determine eligibility unless #5 above applies.

► MEDS requires all of the following documents to be completely filled out and submitted (NCR copies of any forms must be reviewed to ensure documents sent to MEDS are complete and legible):

1. HCS-491,"Disabled or Blind Assessment for Medically Needy", with Section I completed and signed by the applicant and Section II completed and signed by the eligibility case manager;

2. Current SOLQ printout;

3. HCS-492 “Authorization to Release Medical Information to DPHHS”

   NOTE: One HCS-492 must be completed for EACH provider of medical care. Each HCS-492 must be COMPLETELY filled out BY THE APPLICANT/REPRESENTATIVE. No ‘blank, signed’ releases may be sent to MEDS. If the form is signed by a POA, include a copy of the POA document with the forms.

4. HCS-493 "Medical History and Vocational Report" original copy.

5. Forward the forms to: **Medicaid Eligibility Determination Services (MEDS), P.O. Box 20235, Billings, MT 59104**, telephone: (406) 252-1356:

►SSA DECISION ON APPLICANT

When SSA determines a Medicaid applicant is not disabled, but MEDS has determined the applicant is disabled, the MEDS determination is superseded by the SSA decision, and the Medicaid request for coverage based on disability must be denied.

►SSA DECISION ON RECIPIENT

When SSA determines a Medicaid recipient is not disabled, but the individual is already receiving Medicaid as a disabled individual, the following information applies.

EXCEPTION: This process does not apply to a termination of presumptive SSI eligibility. See following caption.

If a Medicaid recipient is found not disabled by SSA (whether after a favorable MEDS determination or when SSA finds that an individual who SSA previously considered disabled no longer meets that criteria):

1. Medicaid is continued during the 60-day period within which an SSA appeal may be filed. The eligibility case manager will set a system alert for the first of the month of the 60th day past the date of the SSA notice of decision, if the eligibility case manager is made aware of the findings in advance.

► **NOTE:** Most SSDI/SSI recipients continue to receive SSDI/SSI benefits during this 60-day appeal period, so this appeal period occurs while the individual is still receiving SSDI and/or SSI benefits. Do not allow an additional 60 days after the termination of the SSDI/SSI benefits in situations where the benefits continued during the appeal period.

► 2. In the month in which the 60-day appeal period expires, send timely notice of Medicaid closure to the recipient using the appropriate system notice. The notice informs the recipient that Medicaid benefits will be terminated at

the end of the month unless they provide verification (within 15 days of the notice) that the disability decision has been appealed to the Social Security Administration. The notice also informs the recipient that if they are unsuccessful in their appeal they may have to repay the Medicaid benefits. (If the recipient was eligible for any other Medicaid program with the same or higher level of benefits during the appeals period, there would be no repayment required.)

3. If the recipient brings in verification of the SSA appeal, continue Medicaid benefits through the appeal process until a decision is reached by the Appeals Council.

► **NOTE:** If the Medicaid recipient is appealing a closure of SSI benefits, do not leave the continued Medicaid benefits open as if the individual continued to receive SSI unless the individual truly continues to receive SSI payments. Authorize the continued Medicaid benefits under an appropriate disabled coverage group.

4. If the recipient does not appeal the decision (timely), or does not provide verification of a timely appeal to OPA within the required 15 days of OPA notice, request sufficient information to determine eligibility under other Medicaid programs (ex parte review).

5. If the recipient is unsuccessful in the appeal to the Appeals Council and there is no eligibility under any other Medicaid program, close Medicaid and send timely notice of adverse action.

► PRESUMPTIVE DISABILITY ENDS

If an individual who is receiving Medicaid due to receipt of presumptive SSI benefits is found to not be disabled by SSA, the SSI benefits are terminated right away, rather than being continued for 60 days.

1. When presumptive SSI benefits are terminated due to SSA determination of no disability, the individual's 60-day appeal period with SSA will still begin as of the date of the decision. The individual's Medicaid eligibility will continue during the 60-day appeal period as well. Authorize the continued Medicaid benefits under an

appropriate disabled coverage group (not related to the receipt of SSI).

2. In the month in which the 60-day appeal period expires, send timely notice of Medicaid closure to the recipient using the appropriate system notice. The notice informs the recipient that Medicaid benefits will be terminated at the end of the month unless they provide verification (within 15 days of the notice) that the disability decision has been appealed to the Social Security Administration. The notice also informs the recipient that if they are unsuccessful in their appeal they may have to repay the Medicaid benefits. (If the recipient was eligible for any other Medicaid program with the same or higher level of benefits during the appeals period, there would be no repayment required.)

3. If the recipient brings in verification of the SSA appeal, continue Medicaid benefits through the appeal process until a decision is reached by the Appeals Council.

4. If the recipient does not appeal the decision (timely), or does not provide verification of a timely appeal to OPA within the required 15 days of OPA notice, request sufficient information to determine eligibility under other Medicaid programs (ex parte review).

PROTECTING APPLICATION DATE

Individuals awaiting an SSA disability decision may indicate an intent to apply for Medicaid by completing Part I of HCS-491,"Disabled or Blind Assessment for Medically Needy".

To utilize the protected application date, the individual must:

1. be denied SSI benefits because of excess income or resources; and
2. file a Medicaid application within 30 days of the SSA denial notice date.

If both conditions are met, the date of the application is the date the HCS-491 was submitted to the OPA rather than the date the Medicaid application is submitted.

VERIFYING SSDIB/SSI BENEFITS

Receipt of SSDI or SSI benefits can be verified using:

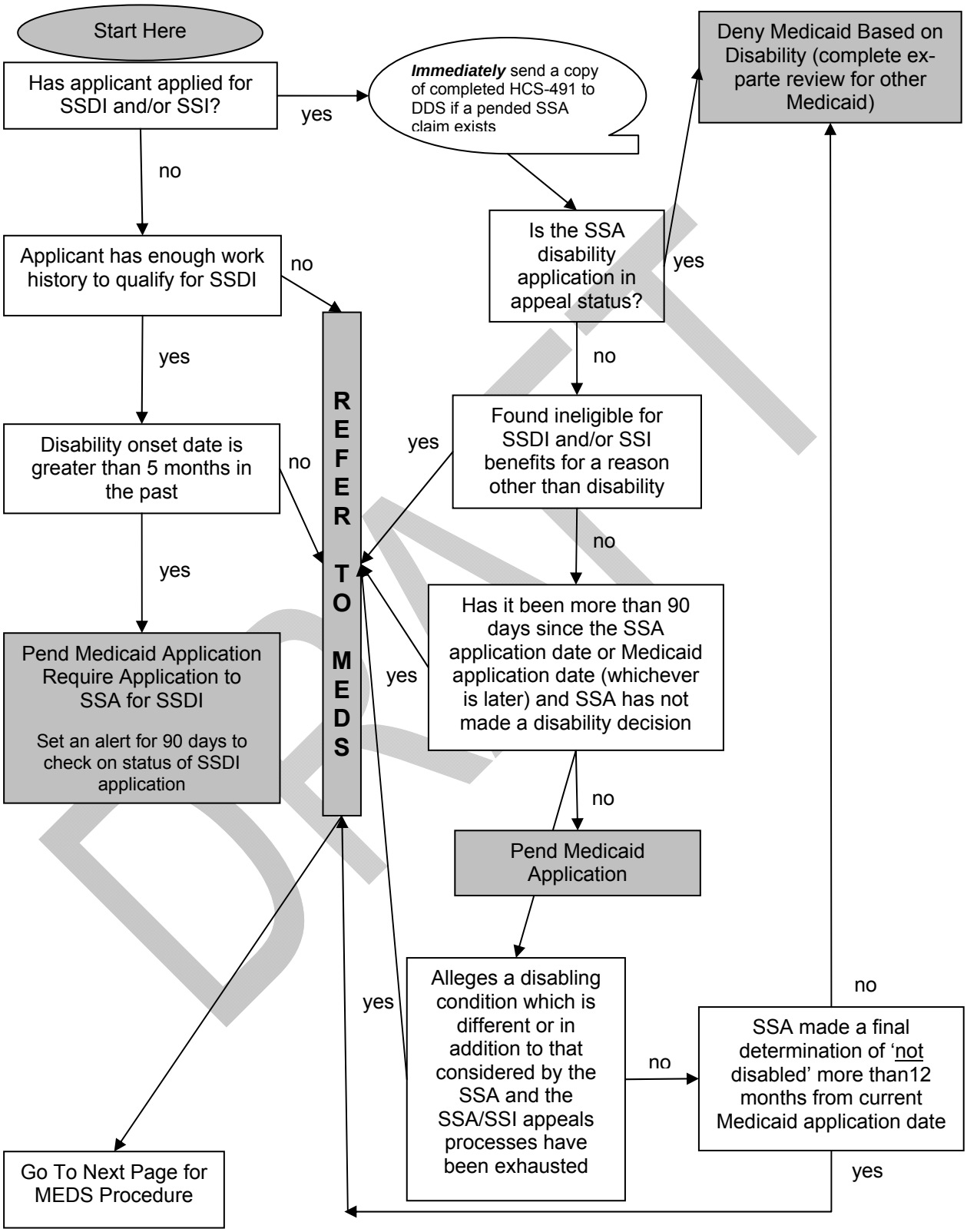
1. Award Letter from SSA; or

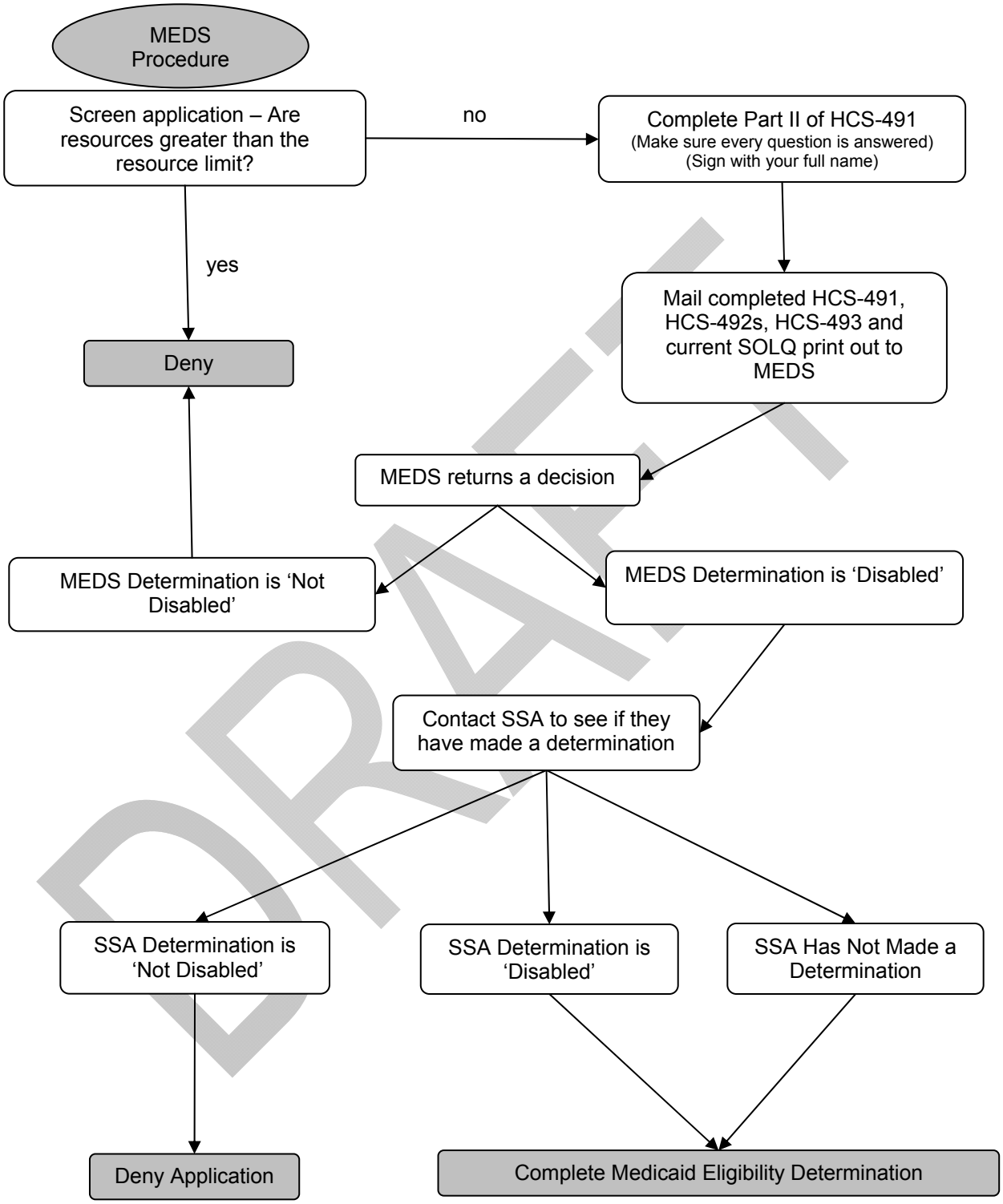
2. System BENDEX inquiry; or
3. SOLQ.

► In some cases, it is necessary to make collateral contact with a local SSA representative to gather clarification or additional information.

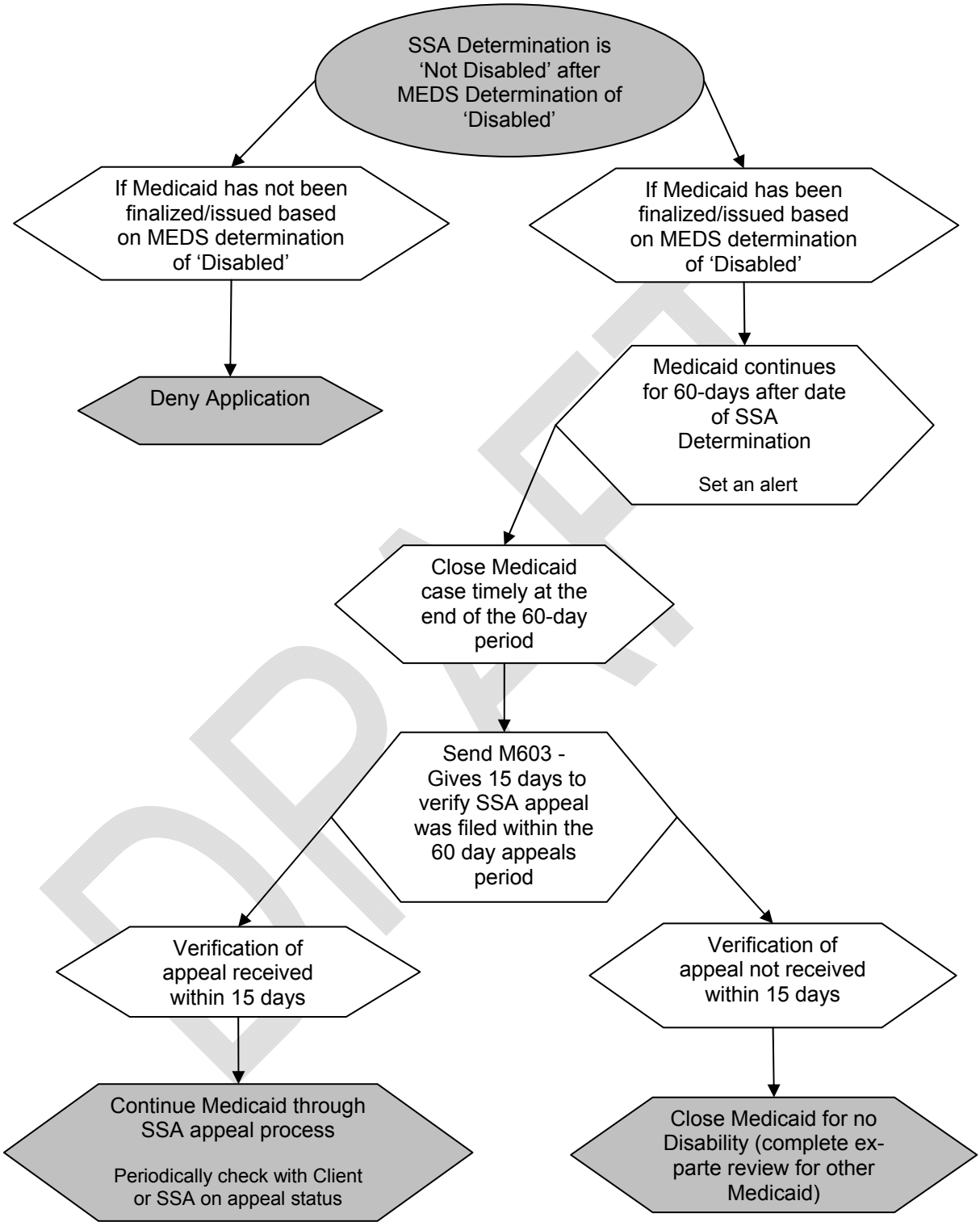
PROCEDURE

Responsibility:	**ACTION**
Applicant/ Representative	1. Submit completed Medicaid application to OPA. Provide required documentation/verification of SSA benefit application;
	2. Complete and sign Part I of HCS-491, "Assessment for Medical Assistance Application, Blind or Disabled";
►Eligibility Case Manager	3. Determine if individual has an SSDI/SSI application pending with SSA.
	4. If the individual has or will be applying for SSDI/SSI, send a complete copy of HCS-491 to: **Disability Determination Services (DDB), P.O. Box 4189, Helena, MT 59604.**
	5. See flowcharts, next three pages.


Start Here
Has applicant applied for SSDI and/or SSI?
yes
Immediately send a copy of completed HCS-491 to DDS if a pended SSA claim exists
Deny Medicaid Based on Disability (complete ex-parte review for other Medicaid)
no
Applicant has enough work history to qualify for SSDI
no
Is the SSA disability application in appeal status?
yes
yes
no
REFER TO MEDS
Disability onset date is greater than 5 months in the past
no
yes
Found ineligible for SSDI and/or SSI benefits for a reason other than disability
yes
no
yes
Pend Medicaid Application Require Application to SSA for SSDI
Set an alert for 90 days to check on status of SSDI application
Has it been more than 90 days since the SSA application date or Medicaid application date (whichever is later) and SSA has not made a disability decision
yes
no
Pend Medicaid Application
yes
Alleges a disabling condition which is different or in addition to that considered by the SSA and the SSA/SSI appeals processes have been exhausted
no
SSA made a final determination of 'not disabled' more than12 months from current Medicaid application date
no
yes
Go To Next Page for MEDS Procedure



Go to Next Page if SSA Determination is 'Not Disabled' after MEDS Determination of 'Disabled'



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